Safe Motherhood Practices

Shatya Narayan Bhatt
Researcher
sbhatt421@gmail.com

Received: Oct, 30, 2016 Revised: Feb, 17, 2017 Accepted: Feb, 18, 2017

Abstract

The study on the "Safe Motherhood Practices in Muslim Community of Nepal". The main objective of the study is to find the knowledge and utilization of safe motherhood practices by the women of reproductive age 15-49 as the target population.

The objective of the study is to examine the utilization of prenatal care, postnatal care and care during delivery and also to find out the level of knowledge, attitude, availability and accessibility of safe motherhood services. The main chosen foe this research are Antenatal checkup, TT vaccination, receiving iron and vitamin 'A', delivery assistance, place of delivery, use of safe delivery kit, postnatal care and time to health services.

Research show that only 47.9 percent received antenatal care, 41.6 percent have received Iron tablets 72.9 percent of respondents have received T.T vaccination and the percent of respondents receiving vitamin 'A' is low that is only 37.5 percent similarly, most respondents (52%) have faced problem during pregnancy.

If we observe the situation delivery care of study population 62.5 percent delivery are occurred in house where as 52.2 percent delivery are assisted by TBA. Similarly, 29.1 percent respondents have safe delivery kit. The study show the utilization of postnatal care is high in the study population i.e. 95.9 percent. But more of respondents 41.3 percent are visited TBA.

Keywords: safe motherhood, Antenatal, postnatal, skilled birth attendants, socio-economic, Awareness

Introduction

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. The importance of maternal health care services in reducing maternal and infant morbidity and mortality has received increasing recognition since the International Conference on Population and Development (ICPD) in Cairo. The utilization of maternal health care is one of the important factors to reduce the incidence of maternal mortality (Mehari, 2012).

They contribute a great deal by performing reproductive and productive responsibility in the society. Nature has gifted the women a capacity of bearing a child. This child bearing is completely a biological process and depends on women's physical state.

Globally, several initiatives have been taken to reduce maternal deaths and improve maternal health, in particular, the Nairobi Safe Motherhood Conference of 1987 (Starrs, 2006). The Nairobi conference led to the establishment of Safe Motherhood Initiative. The specific activities of this initiative include: provision of antenatal care (ANC), skilled assistance for normal deliveries, appropriate referral for women with obstetric complications, postnatal care, family planning and other reproductive health services. Maternal health is further emphasized in the International Conference on Population and Development in 1994 (United Nations, 1995) and Fourth World Conference on Women in 1995 (United Nations, 1996). Importantly, maternal health is reinforced in the United Nations Millennium Summit of 2000, when it was included as one of the Millennium Development Goals (MDGs). The goal, which had the aim to improve maternal health, included two targets: reduce maternal mortality ratio by three quarters between 1990 and 2015 and achieve universal access to reproductive health by 2015. Proportion of births attended by skilled birth attendants (SBAs) and coverage of ANC were the two main indicators to measure these targets. The presence of a skilled birth attendant at delivery, either at home or at a health facility has been strongly emphasized throughout the international initiatives on maternal health.

The Sustainable Development Goals (SDGs) framework has given a high level of priority assigned to health, including maternal, newborn and child health recognizing the critical importance for millions of women and their families. Under the health goal, SDG 3.1 has set the target for maternal mortality reduction: "by 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births specific maternal health indicator". To reach the Ending Preventable Maternal Mortality (EPMM) goal of a global average target of 70 deaths per 100,000 live births, each country will need to contribute a two-thirds reduction in its maternal mortality ratio (MMR) by 2030, regardless of their MMR at baseline. To eliminate the wide inequity in MMRs between countries, a secondary goal is that by 2030, no country should have an MMR that is more than 140, or twice the targeted global average MMR. For countries with very high baseline MMR (greater than 420), a steeper decline will be therefore necessary. In addition to reducing their national average MMR, all countries are called upon to focus on equity and eliminate disparities in maternal mortality among sub-populations (United Nations, 2015).

In keeping with the overall focus of the SDG framework on equity, poverty reduction, human rights, gender equality and empowerment of women and girls, the EPMM targets and strategies call on countries, global partners, donors and implementers, and all decision makers to take a people-centered, context-specific, rights-focused approach, grounded in implementation effectiveness and accountability, to plan for maternal and newborn health and mortality reduction in the post-2015 period (United Nations, 2014). Beyond 2014 has highly emphasized that to eliminate preventable maternal mortality and morbidity, member states should strengthen health systems, including by training midwives and other skilled providers, investing more in emergency obstetric care, and delivering sexual and reproductive health services closer to where people live, especially in rural, remote and impoverished urban areas (United Nations, 2015).

Maternal health remains a significant public health challenge in most developing countries (World Health Organization, 2015). In 2013 alone, world statistics indicated that about 289,000 women died due to causes associated with pregnancies and childbirth (WHO, 2014). Conversely, the recent World Health Organization (WHO) estimates on maternal mortality showed that developed

countries had a consistent low maternal mortality ratio that averaged less than 10 deaths per 100,000 live births for over a decade (World Health Organization, 2015).

Responding to challenges in achieving Millennium Development Goals (MDG), the Ethiopian government initiated the Health Extension Program in 2003 as part of the Health Sector Development Program (HSDP) to improve equitable access to preventive, primitive and select curative health interventions through paid community level health extension workers (Meseret, 2009).

After the establishment of the Ministry of Health in 1956, the Government of Nepal (GoN) started a systematic development of the country's health system through a series of five year plans (Acharya & Cleland, 2000).

- To find out the socio-economic and cultural determinant of safe motherhood practices by WRA in the study area.

This study is important in so as it seeks to find out the extent of general awareness among Muslim women of Nepal about safe motherhood as well as the practices and services utilized by them regarding safe mother hood.

Methods

The Muslim communities residing in different wards of Kapilvastu Municipality. Simple Random sampling process is applied to select the household to collect the data.

The selected wards have total 64 households. The total population of those selected wards is found to be 624. The purpose of the field study was to know examine the level of knowledge and utilization of safe mother hood related services of the women of Muslim community of various wards of Kapilvastu Municipality.

Results and Discussions

This chapter presents the survey finding in the main areas of importance of safe motherhood practices. Antenatal care, delivery care and postnatal care of mother. Data are obtained from women (15 – 49) years for all reported live births which occurred in the last 5 years.

Component of Safe Motherhood

Safe motherhood in any country means to provide good quality care of health to expecting women and mothers of children to the best.

Distribution of respondents by source of information about safe motherhood practices has been presented in Table 1. From table it is clear that 41.6 percent of respondent know through. Neighbor and friends about safe motherhood 25 percent through heath workers and Doctors and only 12.5 percent received information through radio and television.

Table 1 Distribution of Respondents by Source of Information

Age group	Number of Respondents	Percentage
Radio/T.V	6	12.5
Health Workers Private Clinics/Dr	10	20.8

Family Member/ Mother in Low	12	25
Neighbor/ Friends	20	41.6
Total	48	100.00

Source: Field Survey, 2017

Antenatal Care

Antenatal care is the health care and education provided to women during pregnancy. The aim of antenatal care is to screen for and identify high risk factors or condition, provide appropriate management, and keep the mother health until delivery is over. Distribution of respondents by antennal care received during pregnancy has been presented in Table 2 From the table it is clear to see that 47.9 percent of women have received the antenatal care services and 52.0 percent do not take ay health services during pregnancy . The antenatal care is poor situation.

Table 2: Distribution of Respondents by Antenatal Care

Antenatal Care	Number of Respondents	Percentage
Yes	23	47.9
No	25	52.0
Total	48	100

Source: Field Survey, 2017

Women of Muslim community is bounded by "**Burkha**" They are not allowed to take any decision herself. These women are also surrounded by conservative and traditional concept. So suggestion of respondent are very important to receive the antenatal care service. Distribution by person who suggested to receive the antenatal care has been presented in Table 14 from the table it is clear to see that most of women get to suggest by their friend and other suggestion person are lowest. for instance, 60.8 percent of highest women got the suggestion from their friends and second proportion of doctor /Nurse i.e. 17.3 percent.

Table 3 Distribution of Respondents by received the antenatal care service

Person who suggested	Number of Respondents	Percentage
Doctor/Nurse	4	17.3
Husband	3	13.0
Family Member	2	8.6
Friends	14	60.8
Total	23	100

Source: Field Survey, 2017

Visits for Antenatal Care

One indicator of client satisfaction with antenatal care is the degree to which they choose to return for repeat visit after their initial in-counter with the health system. The Municipality survey records and National level records of visits for antenatal care is not same, both have vast different. it is clear to see that out of 48 women in 12 women coverage at first visit for antenatal cure i.e. 52.1 percent. Similarly 26.0 percent of women coverage 2nd time visit, 13.0 percent 3rd time visit and only 8.6 percent of women only coverage four time visited. Regular visits of women are very poor condition in Muslim community.

Table 4 Distribution of Respondent by visit for ANC

No. Of Visit	Number of Respondents	Percentage
1St Visit	12	52.1
2nd Visit	6	26.0

3rd Visit	3	13.0
4th Visit	2	8.6
Total	23	100

Source: Field Survey, 2017

Antenatal Cure Related Services.

Antenatal cure related services are calculated as table to show the distribution of women taking iron tablets, vitamin 'A' and T.T injections during the time of pregnancy.

From the table 5 it is clear to see that 41.6 percent of women take iron tables during pregnancies and 58.3 percent do not. The iron tablet intake of these women are very low, similarly vitamin 'A' is also very poor. The table data shows that only 37.5 percent of respondents take vitamin 'A' table during pregnancies and 62.5 percent do not. When we compromise Iron and vitamin 'A' tablets, Iron tablets is more popular than vitamin 'A'. Vitamin 'A' was not reached up to high level. They comment on personal discussion why we has to use this we are taking milk and vegetables. Pregnant women and newborn necessarily are protected against the tetanus as the T.T injections to prevent the mother and child from tetanus. Pregnant women are receive of T.T to protect herself and unborn child full during the pregnancy. The T.T injection in this community. 72.9 percent. which is not satisfaction.

Table 6 Distribution of Respondents by Related Antenatal Care

Antenatal Care Related Services	Number of Respondents	Percentage
Iron Tablets		
Yes	20	41.6
No	28	58.3
Tetanus taxed injection		
Yes	35	72.9
No	13	27.0
Vitamin 'A'		
Yes	18	37.5
No	30	62.5

Source: Field Survey, 2017

Condition of Extra Food

Condition of extra food is also important factor in this community. Some of respondents do not know that what is extra food ? Distribution of respondents by extra food has been presented in Table 7. From the table it is clear to see that women in the study area are not likely to eat at pregnancy time. For instance 37.5 percent i.e. 18 in number of respondents eat extra food, 56.2 percent do not any extra food eat and the percent who do not know is 6.2 percent so, extra food condition is bad.

Table - 7 Distribution of respondents by extra food

Extra Food	Number of Respondents	Percentage
Yes	18	37.5
No	27	56.2
Don't know	3	6.2
Total	48	100

Source: Field Survey, 2017

Utilization of ANC by Education

Education level of the population is an important indication of social development of a place or a country. Education also affects the reproductive behaviour of mother and their children, with regard to education follows a typical pattern of socio-economic development in which urban trend to get more benefits of development as compared with rural areas.

Distribution of respondents according to antenatal care by educational status has been presented in Table -8. From the table it is clear that Literate women are more exposure to the ANC. Among 23 literate cases 65.2 percent literate women have received antenatal care during pregnancy and 34.7 percent women haven't receive.

In literate, the antenatal care is increased with increasing the level of education. Only 33 percent literate from primary education level said yes for ANC, but who have completed lower secondary said yes 50 percent where as secondary said yes by 100percent (percent), S.L.C./under graduate said 76.9 percent and graduate 66.6 Percent.

Table - 8 Distribution of Respondent On Utilization of ANC

Literacy	Utilization of ANC				
	Yes		No		Total Number
	Number	Percent	Number	Percent	
Literate	15	65.2	8	34.7	23
Illiterate	5	21.7	20	86.9	25
Total	20	41.6	28	58.3	48

Level of education

Literacy	Utilization of ANC				
	Yes		No		Total Number
	Number	Percent	Number	Percent	
Primary	1	33.0	2	66.6	3
Lower Secondary	1	50.0	1	50.0	2
Secondary	2	100.0	0	0.0	2
S.L.C. /under graduate	10	76.9	3	23.0	13
Graduate	2	66.9	1	33.3	3
Total	16	69.5	7	30.43	23

Source: Field Survey, 2017

Utilization of ANC by Occupation

Distribution of respondent according to Antenatal care by occupation has been presented in table - 9 From the table it is clear to see that respondent who are involved in NGO's and health sector have high majority of at antenatal care service during the pregnancy. For instance 100 percent of these respondent have received antenatal service and only 20 percent of daily wage agriculture respondent have received antenatal care. It is very poor than all occupational respondents. Similarly 37.5 percent of agricultural respondent have received antenatal care and 50 percent of household works respondent have received antenatal care.

Table -9 Distribution of respondents according to ANC by occupation

Occupation	**Received ANC**

	Yes	Percent	No	Percent	Total
Agriculture	6	37.	10	62.5	16
Household work	4	50.00	4	50.00	8
Teaching	3	75.00	1	25.00	4
NGO's	2	100.00	0	0.0	2
Health sectors	3	100.00	0	0.0	3
Daily wage Agri.	1	20.00	4	80.0	5
Daily wage non Agriculture	3	50.00	3	50.0	6
Cottage industries	1	25.00	3	75.0	4
Total	23		25		48

Source: Field Survey, 2017

Delivery care Services

Delivery care service is to protect the life and health of the mother, and to ensure the delivery of a healthy baby. This section present to follow on the place of delivery, delivery assisted, use of safe delivery kit, use of cut the cored and colostrums feeding by baby.

Place of Delivery

The place where the delivery takes place is one of the most important aspects of the safemother. But, in our country most of the delivery tale place in extremely un-hygienic condition. This is dangerous procedure for both the mother and her new born baby. In Kapilvastu Municipality most of the Muslim women are used to place of delivery at home. Distribution of respondents by place of birth has been presented in Table 23. From the table it is clear that 62.8 percent of delivery take place at home, 20.8 percent of deliveries at hospital and 16.7 percent of deliveries at private/clinic/Nurse.

Table - 10 Distribution of respondents by place of births

Place of delivery	Number of women	Percent
Home	30	62.5
Hospital	10	20.8
Private clinic	8	16.7
Total	48	100.00

Source: Field Survey, 2017

Delivery Assisted

In our society, most of delivery are assisted by birth attendants. Table - 24 show delivery assisted duang birth of baby. it is clear from the table - 11 that 52.2 percent of women delivery take place at home by sudeni only 8.3 percent are assisted by Doctor/Nurse, and 20.8 percent are assisted by relatives (untrained). In modern time, Doctor/Nurse data is not effectible. In spite 20.8 percent delivery are not assisted to medical person. But TBAS are not also pure medical perception. only the they take to training about delivery. More TBAS

are illiterate in there, so that delivery assisted person is not suitable in Kapilvstu Municipality and also this is due to the traditional belif of Muslim community.

Table - 11 Distribution of respondents delivery assited

Assisted person	No. Of respondents	Percentage
Family member	10	20.8
Relative	6	12.5
TBA (Sudeni)	25	52.2
FCHV	3	6.2
Doctor /Nurse	4	8.3
Total	48	100.00

Source: Field Survey, 2017

Use of Safe Delivery Kit

A safe delivery kit is a small medical box used at the time of delivery. The small prepared kit contains a razor, a blade, cutting surface, a plastic sheet, a piece of soap, a string and child health product for safe delivery services. Distribution of respondents by safe delivery kit has been presented in table 25. The table shows that the high majority of deliveries don't know about safe delivery kit. More or less number of women are using delivery kit. For instance 58.3 percent of respondents don't know about safe delivery kit where as 29.1percent respondents are using kit.

Table 12 Distribution of Respondents by Safe Delivery Kit

Safe Delivery Kit	No.	Percent
Yes	14	29.1percent
No	6	12.5percent
Don't know	28	58.3percent
Total	48	100percent

Source field survey 2008

Mean Used to Cut the Cord

It is also very important factor in the safe motherhood. In the past, more mother had died in cause of use to cut the cord. But in the modern time all of most Muslim women are used the sterilized blade. As table - 26 it is clear to see that 93.8 percent of total 48 respondents are used the sterilized blade, 6.2 percent don't use the sterilized blade.

Table - 13 Distribution of Respondents by Means use to cut the Cord.

Name of instrument	No. of respondents	Percentage
sterilized blade	45	93.8
Non sterilized blade	03	6.2
Others	0	0
Total	48	100.0

Source: Field Survey, 2017

Colostrums Feeding Practices

Distribution of respondents by colostrums feeding has been presented in table - 14. From table it is clear to see that Muslim women in study area not likely to colostrums feeding. Form instance only 35.5 percent of respondents baby and most of respondents don't feeding i.e. 62.5 percent this is due to social problems in Muslim community. More of women though that yellow milk (colostrums) is not suitable to baby and it has poison effect.

Table - 14 Distribution of Respondents by colostrums feeding

Colostrums Feeding	No. of Respondents	Percentage
Yes	18	37.5
No	30	62.5
Total	48	100.0

Source: Field Survey, 2017

Postnatal Care

Postnatal care services is to ensure the health of mothers who recently gave birth as well their new born during first - six weeks of life. It helps to reduce maternal and neonatal mortality and morbidity distribution of respondents by postnatal care has been presented in Table 15. From the table it is clear to see that women in study area likely to take postnatal care. From instance 95.9 percent of respondents have received postnatal care and only 4.1 percent of respondents don't receive.

Table - 15 Distribution of respondent by postnatal care

Postnatal care	No. of respondents	Percentage
Yes	46	95.9
No	2	4.1
Total	48	100.0

Source: Field Survey, 2017

Facilities Used for Postnatal Care

Distribution of respondents by received health facilities have been presented in Table - 16. From the table it is clear to see that large number of Muslim women are visited TBA services and only 4.3 percent respondents visited the FCHV. High medical facilities are not effective. Among the total no of respondents who received that 32.5 percent are visited Hospital and 21.8 percent private clinics.

Table - 16 Facilities use for Postnatal Care

Health centers	No. of respondents	Percentage
TAB	19	41.3
FCHV	2	4.3
Hospital	15	32.6
Private /Clinics	10	21.8
Total	46	100.0

Source: Field Survey, 2017

Conclusion

Women of certain case/ethnic group are deprived of any level of formal education which has afflicted their opinion, knowledge and attitude towards the practice of safe motherhood services. People who occupy relatively low social position are poor in economic terms, which also contribute for the low acceptance of safe motherhood services. Most of the respondents have knowledge about safe motherhood services but in actual practice their perception towards safe motherhood services and utilization of services lower. Social economic and educational status has played vital roles in determining the utilization of all the safe motherhood services.

The status of women must be raised by providing them opportunities an income generating programs and should be given more education. The awareness about the safe motherhood related services in the women of the community are very low. A woman makes a house educated when she herself is aware and educated. So extra effort should be done to educate the women about the safe motherhood practices so that she can make the rest of her family, especially the new

generation aware and educated about it moreover, extra effort should be done to make the families send their daughters to school along with their son so as to increase the educational status of women and the community, either by giving extra facilities or by making good policies and putting them in quick action.

References

Acharya , L. B., & Cleland, J. (2000). *Maternal and child health services in rural Nepal: does access or quality matter more? Health Policy Plan.* . Retrieved from DOI: 10.1093/heapol/15.2.223

Mehari, K. (2012). *Determinants of utilization of maternal health care,services among mothers in Harare, Zimbabwe.* Eunice Nyarambi: Paddington Tinashe Mundagowa.

Meseret, G. (2009). *Lifesaving emergency obstetric services are inadequate in Pradesh? Evidence from district level household survey, international services in rural Ethiopia.* Addis Ababa Ethiopia: Addis Ababa University.

Ministry of Health and Population . (2016). *). Nepal Demographic and Health Survey 2016. Kathmandu, Nepal: Ministry of Health and Population.* New ERA, and ICF International Inc: Calverton, Maryland.

Starrs, A. M. (2006). *Safe Motherhood Initiative: 20 Years and Counting.* New York: Family Care International,NY 10012, USA. astarrs@familycareintl.org.

United Nations. (1995). *A Social Determinants Approach to Maternal Health: Discussion Paper.* . New York: United Nations Development Programme.

United Nations. (1996). *Report of the Fourth World Conference on Women, 1995. Report of the Fourth World Conference on Women, 1995, September 4-15, Beijing.* New York: United Nations.

United Nations. (2014). *The Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (ICPD) Beyond 2014.* New York: United Nations, Economic and Social Council.

United Nations. (2015). *Goal 3—The SDGs and a Healthier 2030.* New York: UN Chronicle: The Magazine of the United Nations, Vol. LI No. 42014. .

WHO. (2014). *Trends in maternal mortality: 1990 to 2013 estimates developed by WHO, UNICEF, UNFPA and The World Bank.* Geneva: WHO.

World Health Organization. (2015). *Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.* Geneva: WHO.